Request to Change Lock–in Pharmacy

One pharmacy change allowed in a six-month period (unless good cause)

Recipient Name: ____

Recipient Member Number: ____

Recipient Address: ____

Recipient City, State Zip:____________________ Recipient Phone Number:__________________

Reason for Pharmacy Change Request:____

____

I want to change my "Lock-In" Pharmacy to the following:

Pharmacy Name:____

Pharmacy Address:____

Pharmacy City, State Zip:____

Pharmacy Phone Number: ____

Pharmacy Fax Number: ____

Pharmacy License Number:____

Please make this change effective as of mm/dd/yyyy: _______/_______/________

Recipient Signature _________________________________ Medicaid ID: ________________

Fax completed form to: 1-866-351-7388 or mail to the address below:

Ambetter from Sunshine Health
Attn: Pharmacy Department
1301 International Pkwy Suite 400
Sunrise, FL 33323